

FILLED NOV 12 1941

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

35588

Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid

Registration District No. 60

(b) Township Como

Primary Registration District No. 5-901

Registered No. 35588

(c) City Como

(d) Street No. 1 (If death occurred in Hospital or Institution, write its name instead of street and number) St. 1

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds. 0

2. PRINT FULL NAME

William N. Gilbow

(a) Residence, No. New Madrid Co. Mo. St. 1

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

79

7

20

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

Farmer

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (imprisoned year) July 1939

11. Total time (years) spent in this occupation 60 yrs

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Conran

Missouri

FATHER

13. NAME

William Gilbow

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

L. A. Gilbow

Parma, Missouri.

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

19

19. FUNERAL DIRECTOR (NAME) (ADDRESS)

20. FILED

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

19

22. I HEREBY CERTIFY, That I attended deceased from 9-5-41, 19, to 9-10-41, 19.

I last saw him alive on 9-6-41, 19. Death is said to have occurred on the date stated above, at 4:15 PM

The principal cause of death and related causes of importance were as follows:

Chronic Myocardial

Degeneration

Date of onset

Other contributory causes of importance:

Acute Diarrhea

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Parma, Missouri

(Address)

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

32111

RECEIVED

District Health Office No. 2,

District File Number 1141-1511

Date Filed 11/10/41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, Sept 11,  
\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_,  
working under my personal supervision.

Signed

Robert E. Allen

Licensed Embalmer No.

4218

P. O. Address

Albany, N. Y.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 85585

Registration District No. 605

Primary Registration District No. 4359

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME William N. Gilbow

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan 120 1868  
(Month) (Day) (Year)

8. AGE: Years 79 Months 7 Days 29 If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) Portageville Mo. (b) Date thereof 9 12 41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Portageville Mo

18. (a) Signature of funeral director [Signature]

(b) Address \_\_\_\_\_

19. (a) 9-12-41 (b) Dr. W. N. Husted  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day 10 Year 41 hour \_\_\_\_\_ minute 4:30 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to Carcinoma mouth

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_ Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

3214